February 13, 2009

SENATE BILL No. 454

DIGEST OF SB 454 (Updated February 11, 2009 2:38 pm - DI 104)

Citations Affected: IC 23-2; noncode.

Synopsis: Medicaid health facility quality assessment fee. Revises the definition of "continuing care agreement" to mean agreements requiring the payment of an entrance fee of at least $25,000. Specifies when a person providing continuing care has to register the home with the securities commissioner. Eliminates payments to the Indiana retirement home guaranty fund after June 30, 2009. Removes provisions limiting the health facilities subject to the quality assessment fee based on the health facility's Medicaid utilization rate and annual Medicaid revenue. Eliminates the exemption from the quality assessment fee for health facilities that only receive Medicare revenues. Provides an exemption for hospital based health facilities. Specifies conditions that a continuing care retirement community must meet in order to be exempt from the quality assessment fee. Eliminates the role of the department of state revenue in collecting quality assessment fees. Extends the health facility quality assessment fee until August 1, 2011. (The fee currently expires August 1, 2009.)

Effective: January 1, 2009 (retroactive); July 1, 2009.

Miller, Mishler, Sipes

January 14, 2009, read first time and referred to Committee on Health and Provider Services.
February 12, 2009, amended, reported favorably — Do Pass.

February 13, 2009

First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

SENATE BILL No. 454

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 23-2-4-1, AS AMENDED BY P.L.27-2007, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means an agreement by a provider to furnish to ~~at least one (1)~~ **an** individual, for the payment of an entrance fee **of at least twenty-five thousand dollars ($25,000)** and periodic charges:

(1) accommodations in a ~~living unit of a home and.~~ **continuing care retirement community;**

~~(1)~~ **(2)** meals and related services;

~~(2)~~ **(3)** nursing care services;

~~(3)~~ **(4)** medical services;

~~(4)~~ **(5)** other health related services; or

~~(5)~~ **(6)** any combination of these services;

for the life of the individual, ~~or for more than one (1) month.~~ **unless the agreement is terminated as specified under this chapter.**

"Continuing care retirement community" includes both of the following:

(1) An independent living facility.

(2) A health facility licensed under IC 16-28.

"Contracting party" means a person or persons who enter into a continuing care agreement with a provider.

"Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, to a provider in consideration for one (1) or more individuals becoming a resident of a home under a continuing care agreement.

"Home" means a facility where the provider undertakes, pursuant to a continuing care agreement, to provide continuing care to five (5) or more residents.

"Living unit" means a room, apartment, cottage, or other area within a home set aside for the use of one (1) or more identified residents.

"Long term financing" means financing for a period in excess of one (1) year.

"Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the disclosure statement or registration, in light of the circumstances under which they were made, not misleading.

"Person" means an individual, a corporation, a partnership, an association, a limited liability company, or other legal entity.

"Provider" means a person that agrees to provide continuing care ~~to an individual~~ under a continuing care agreement.

"Refurbishment fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in refurbishing a previously occupied living unit specifically designated for occupancy by that individual.

"Resident" means an individual who is entitled to receive benefits under a continuing care agreement.

"Solicit" means any action of a provider in seeking to have an individual residing in Indiana pay an application fee and enter into a continuing care agreement, including:

(1) personal, telephone, or mail communication or any other communication directed to and received by any individual in Indiana; and

(2) advertising in any media distributed or communicated by any means to individuals residing in Indiana.

"Termination" refers to the cancellation of a continuing care agreement under this chapter.

SECTION 2. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A provider shall register each home with the commissioner **if:**

(1) before opening the home, the provider:

(A) enters into;

(B) extends; or

(C) solicits;

a continuing care agreement; or

(2) while operating the home, the provider has entered into a continuing care agreement with at least twenty-five percent (25%) of the individuals living in the independent living part of the home.

(b) If a provider fails to register a home, the provider may not:

(1) enter into, or extend the term of, a continuing care agreement to provide continuing care to any person at that home;

(2) provide services at that home under a continuing care agreement; or

(3) solicit the execution, by persons residing within Indiana, of a continuing care agreement to provide continuing care at that home.

~~(b)~~ **(c)** The provider's application for registration must be filed with the commissioner by the provider on forms prescribed by the commissioner, and must be accompanied by an application fee of two hundred fifty dollars ($250). The application must contain the following information:

(1) an initial disclosure statement, as described in section 4 of this chapter; and

(2) any other information required by the commissioner under rules adopted under this chapter.

~~(c)~~ **(d)** The commissioner may accept, in lieu of the information required by subsection ~~(b),~~ **(c),** any other registration, disclosure statement, or other document filed by the provider in Indiana, in any other state, or with the federal government if the commissioner determines that such document substantially complies with the requirements of this chapter.

~~(d)~~ **(e)** Upon receipt of the application for registration, the commissioner shall mark the application filed. Within sixty (60) days of the filing of the application, the commissioner shall enter an order

registering the provider or rejecting the registration. If no order of rejection is entered within that sixty (60) day period, the provider shall be considered registered unless the provider has consented in writing to an extension of time; if no order of rejection is entered within the time period as extended by consent, the provider shall be considered registered.

~~(c)~~ **(f)** If the commissioner determines that the application for registration complies with all of the requirements of this chapter, the commissioner shall enter an order registering the provider. If the commissioner determines that such requirements have not been met, the commissioner shall notify the provider of the deficiencies and shall inform the provider that it has sixty (60) days to correct them. If the deficiencies are not corrected within sixty (60) days, the commissioner shall enter an order rejecting the registration. The order rejecting the registration shall include the findings of fact upon which the order is based. The provider may petition for reconsideration, and is entitled to a hearing upon that petition.

SECTION 3. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: **Sec. 7.5. A continuing care agreement may be terminated for any of the following reasons:**

(1) The provider has determined that the resident is inappropriate for living in the care setting.

(2) The resident is unable to fully pay the periodic charges because the resident inappropriately divested the assets and income the resident identified at the time of admission to meet the ordinary and customary living expenses for the resident.

(3) Providing assistance to the resident would jeopardize the financial solvency of the provider and the other residents being served by the provider.

(4) The resident has requested a termination of the agreement as allowed under the agreement.

SECTION 4. IC 23-2-4-13, AS AMENDED BY P.L.2-2006, SECTION 180, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the Indiana retirement home guaranty fund. The purpose of the fund is to provide a mechanism for protecting the financial interests of residents and contracting parties in the event of the bankruptcy of the provider.

(b) To create the fund, a guaranty association fund fee of one hundred dollars ($100) shall be levied on each contracting party who enters into a continuing care agreement after August 31, 1982, **and before July 1, 2009.** The fee shall be collected by the provider and

forwarded to the commissioner within thirty (30) days after occupancy by the resident. Failure of the provider to collect and forward such fee to the commissioner within that thirty (30) day period shall result in the imposition by the commissioner of a twenty-five dollar ($25) penalty against the provider. In addition, interest payable by the provider shall accrue on the unpaid fee at the rate of two percent (2%) a month.

(c) Any money received by the commissioner under subsection (b) shall be forwarded to the treasurer of state. The fund, and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the treasurer of state in the same manner as provided in IC 20-49-3-10 for investment of the common school fund.

(d) All reasonable expenses of collecting and administering the fund shall be paid from the fund.

(e) Money in the fund at the end of the state's fiscal year shall remain in the fund and shall not revert to the general fund.

SECTION 5. P.L.3-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: SECTION 1. (a) **As used in this SECTION, "continuing care retirement community" means a health care facility that:**

(1) provides independent living services, assisted living services, and health facility services in a campus setting with common areas;

(2) enters into a continuing care agreement with a resident (as defined in IC 23-2-4-1);

(3) uses the money described in subdivision (2) to provide services to the resident before the resident may be eligible for Medicaid under IC 12-15; and

(4) meets the requirements of IC 23-2-4.

(b) As used in this SECTION, "health facility" refers to a health facility that is licensed under IC 16-28 as a comprehensive care facility.

~~(b)~~ **(c)** As used in this SECTION, "nursing facility" means a health facility that is certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

~~(c)~~ **(d)** As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

~~(d) As used in this SECTION, "total annual revenue" does not include revenue from Medicare services provided under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).~~

~~(e)~~ **(e)** Effective August 1, ~~2003,~~ **2009,** the office shall collect a quality assessment from each ~~nursing~~ **health** facility. ~~that has:~~

~~(1) a Medicaid utilization rate of at least twenty-five percent~~

~~(25%); and~~

~~(2) at least seven hundred thousand dollars ($700,000) in annual Medicaid revenue, adjusted annually by the average annual percentage increase in Medicaid rates.~~

The office shall offset the collection of the assessment for a health facility:

(1) against a Medicaid payment to the health facility by the office; or

(2) in another manner determined by the office.

(f) ~~If~~ **The office shall implement the waiver approved by** the United States Centers for Medicare and Medicaid Services ~~determines not to approve payments under this SECTION using the methodology described in subsection (e), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii). The revised state plan amendment and waiver request must provide~~ **that provides** for ~~the following:~~

~~(1) Effective August 1, 2003, collection of a quality assessment by the office from each nursing facility.~~

~~(2) Effective August 1, 2003, collection of a quality assessment by the department of state revenue from each health facility that is not a nursing facility.~~

~~(3) An~~ **an** exemption from collection of a quality assessment from the following:

~~(A)~~

(1) A continuing care retirement community, **subject to the following conditions:**

(A) A nonprofit organization that is:

(i) exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code; and

(ii) registered under IC 23-2-4 before July 1, 2009;

is not required to meet the definition of continuing care retirement community in subsection (a).

(B) A continuing care retirement community that does not meet the provisions of clause (A)(i) and (A)(ii) must meet the definition set forth in subsection (a).

~~(B) A health facility that only receives revenue from Medicare services provided under 42 U.S.C. 1395 et seq.~~

~~(C)~~

(2) A **hospital based** health facility. ~~that has less than seven hundred fifty thousand dollars ($750,000) in total annual revenue, adjusted annually by the average annual percentage increase in~~

~~Medicaid rates.~~

~~(D)~~

(3) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(g) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsections **(d) and** (e), ~~and (f),~~ the office shall revise the state plan amendment and waiver request submitted under ~~subsection (l)~~ **this SECTION** as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii) and to provide for collection of a quality assessment from health facilities effective August 1, ~~2003.~~ **2009.** ~~In amending the state plan amendment and waiver request under this subsection, the office may modify the parameters described in subsection (f)(3). However, if the office determines a need to modify the parameters described in subsection (f)(3), the office shall modify the parameters in order to achieve a methodology and result as similar as possible to the methodology and result described in subsection (f). Any revision of the state plan amendment and waiver request under this subsection is subject to and must comply with the provisions of this SECTION.~~

(h) The money collected from the quality assessment may be used only to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) Twenty percent (20%) as determined by the office.

(2) Eighty percent (80%) to nursing facilities.

(i) After:

(1) the amendment to the state plan and waiver request submitted under this SECTION is approved by the United States Centers for Medicare and Medicaid Services; and

(2) the office calculates and begins paying enhanced reimbursement rates set forth in this SECTION;

the office ~~and the department of state revenue~~ shall begin the collection of the quality assessment set under this SECTION. The office ~~and the department of state revenue shall~~ **may** establish a method to allow a facility to enter into an agreement to pay the quality assessment collected under this SECTION subject to an installment plan.

(j) If federal financial participation becomes unavailable to match money collected from the quality assessments for the purpose of enhancing reimbursement to nursing facilities for Medicaid services

provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office ~~and department of state revenue~~ shall cease collection of the quality assessment under this SECTION.

(k) To implement this SECTION, the

~~(1)~~ office shall adopt rules under IC 4-22-2. ~~and~~

~~(2) office and department of state revenue shall adopt joint rules under IC 4-22-2.~~

(l) Not later than ~~July 1, 2003,~~ **August 1, 2009,** the office shall do the following:

(1) Request the United States Department of Health and Human Services under 42 CFR 433.72 to approve waivers of 42 CFR 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance with 42 CFR 433.68(e)(2)(ii).

(2) Submit any state Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to implement this SECTION.

(m) After approval of the waivers and state Medicaid plan amendment applied for under ~~subsection (l),~~ **this SECTION,** the office ~~and the department of state revenue~~ shall implement this SECTION effective ~~July 1, 2003.~~ **August 1, 2009.**

(n) The select joint commission on Medicaid oversight, established by IC 2-5-26-3, shall review the implementation of this SECTION. The office may not make any change to the reimbursement for nursing facilities unless the select joint commission on Medicaid oversight recommends the reimbursement change.

(o) A nursing facility or a health facility may not charge the facility's residents for the amount of the quality assessment that the facility pays under this SECTION.

(p) The office may withdraw a state plan amendment **submitted** under ~~subsection (c), (f), or (g)~~ **this SECTION** only if the office determines that failure to withdraw the state plan amendment will result in the expenditure of state funds not funded by the quality assessment.

(q) If a health facility fails to pay the quality assessment under this SECTION not later than ten (10) days after the date the payment is due, the health facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(r) The ~~following shall be provided to the state department of health:~~

~~(1) The~~ office shall report **to the state department of health** each nursing **facility and each health** facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality

assessment is due.

~~(2) The department of state revenue shall report each health facility that is not a nursing facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.~~

(s) The state department of health shall do the following:

(1) Notify each nursing facility and each health facility reported under subsection (r) that the nursing facility's or health facility's license under IC 16-28 will be revoked if the quality assessment is not paid.

(2) Revoke the nursing facility's or health facility's license under IC 16-28 if the nursing facility or the health facility fails to pay the quality assessment.

(t) An action taken under subsection (s)(2) is governed by:

(1) IC 4-21.5-3-8; or

(2) IC 4-21.5-4.

(u) The office shall report the following information to the select joint commission on Medicaid oversight established by IC 2-5-26-3 at every meeting of the commission:

(1) Before the quality assessment is approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the progress in receiving approval for the quality assessment; and

(B) a summary of any discussions with the United States Centers for Medicare and Medicaid Services.

(2) After the quality assessment has been approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the collection of the quality assessment;

(B) a summary of the quality assessment payments owed by a nursing facility or a health facility; and

(C) any other relevant information related to the implementation of the quality assessment.

(v) This SECTION expires August 1, ~~2009.~~ **2011.**

SECTION 6. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 454, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 23-2-4-1, AS AMENDED BY P.L.27-2007, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means an agreement by a provider to furnish to ~~at least one (1)~~ **an** individual, for the payment of an entrance fee **of at least twenty-five thousand dollars ($25,000)** and periodic charges:

(1) accommodations in a ~~living unit of a home and.~~ **continuing care retirement community;**

~~(1)~~ **(2)** meals and related services;

~~(2)~~ **(3)** nursing care services;

~~(3)~~ **(4)** medical services;

~~(4)~~ **(5)** other health related services; or

~~(5)~~ **(6)** any combination of these services;

for the life of the individual, ~~or for more than one (1) month.~~ **unless the agreement is terminated as specified under this chapter.**

"Continuing care retirement community" includes both of the following:

(1) An independent living facility.

(2) A health facility licensed under IC 16-28.

"Contracting party" means a person or persons who enter into a continuing care agreement with a provider.

"Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, to a provider in consideration for one (1) or more individuals becoming a resident of a

home under a continuing care agreement.

"Home" means a facility where the provider undertakes, pursuant to a continuing care agreement, to provide continuing care to five (5) or more residents.

"Living unit" means a room, apartment, cottage, or other area within a home set aside for the use of one (1) or more identified residents.

"Long term financing" means financing for a period in excess of one (1) year.

"Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the disclosure statement or registration, in light of the circumstances under which they were made, not misleading.

"Person" means an individual, a corporation, a partnership, an association, a limited liability company, or other legal entity.

"Provider" means a person that agrees to provide continuing care ~~to an individual~~ under a continuing care agreement.

"Refurbishment fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in refurbishing a previously occupied living unit specifically designated for occupancy by that individual.

"Resident" means an individual who is entitled to receive benefits under a continuing care agreement.

"Solicit" means any action of a provider in seeking to have an individual residing in Indiana pay an application fee and enter into a continuing care agreement, including:

(1) personal, telephone, or mail communication or any other communication directed to and received by any individual in Indiana; and

(2) advertising in any media distributed or communicated by any means to individuals residing in Indiana.

"Termination" refers to the cancellation of a continuing care agreement under this chapter.

SECTION 2. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A provider shall register each home with the commissioner **if:**

(1) before opening the home, the provider:

(A) enters into;

(B) extends; or

(C) solicits;

a continuing care agreement; or

(2) while operating the home, the provider has entered into a continuing care agreement with at least twenty-five percent

(25%) of the individuals living in the independent living part of the home.

(b) If a provider fails to register a home, the provider may not:

(1) enter into, or extend the term of, a continuing care agreement to provide continuing care to any person at that home;

(2) provide services at that home under a continuing care agreement; or

(3) solicit the execution, by persons residing within Indiana, of a continuing care agreement to provide continuing care at that home.

~~(b)~~ **(c)** The provider's application for registration must be filed with the commissioner by the provider on forms prescribed by the commissioner, and must be accompanied by an application fee of two hundred fifty dollars ($250). The application must contain the following information:

(1) an initial disclosure statement, as described in section 4 of this chapter; and

(2) any other information required by the commissioner under rules adopted under this chapter.

~~(c)~~ **(d)** The commissioner may accept, in lieu of the information required by subsection ~~(b),~~ **(c),** any other registration, disclosure statement, or other document filed by the provider in Indiana, in any other state, or with the federal government if the commissioner determines that such document substantially complies with the requirements of this chapter.

~~(d)~~ **(e)** Upon receipt of the application for registration, the commissioner shall mark the application filed. Within sixty (60) days of the filing of the application, the commissioner shall enter an order registering the provider or rejecting the registration. If no order of rejection is entered within that sixty (60) day period, the provider shall be considered registered unless the provider has consented in writing to an extension of time; if no order of rejection is entered within the time period as extended by consent, the provider shall be considered registered.

~~(e)~~ **(f)** If the commissioner determines that the application for registration complies with all of the requirements of this chapter, the commissioner shall enter an order registering the provider. If the commissioner determines that such requirements have not been met, the commissioner shall notify the provider of the deficiencies and shall inform the provider that it has sixty (60) days to correct them. If the deficiencies are not corrected within sixty (60) days, the commissioner shall enter an order rejecting the registration. The order rejecting the

registration shall include the findings of fact upon which the order is based. The provider may petition for reconsideration, and is entitled to a hearing upon that petition.

SECTION 3. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: **Sec. 7.5. A continuing care agreement may be terminated for any of the following reasons:**

(1) The provider has determined that the resident is inappropriate for living in the care setting.

(2) The resident is unable to fully pay the periodic charges because the resident inappropriately divested the assets and income the resident identified at the time of admission to meet the ordinary and customary living expenses for the resident.

(3) Providing assistance to the resident would jeopardize the financial solvency of the provider and the other residents being served by the provider.

(4) The resident has requested a termination of the agreement as allowed under the agreement.

SECTION 4. IC 23-2-4-13, AS AMENDED BY P.L.2-2006, SECTION 180, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the Indiana retirement home guaranty fund. The purpose of the fund is to provide a mechanism for protecting the financial interests of residents and contracting parties in the event of the bankruptcy of the provider.

(b) To create the fund, a guaranty association fund fee of one hundred dollars ($100) shall be levied on each contracting party who enters into a continuing care agreement after August 31, 1982, **and before July 1, 2009.** The fee shall be collected by the provider and forwarded to the commissioner within thirty (30) days after occupancy by the resident. Failure of the provider to collect and forward such fee to the commissioner within that thirty (30) day period shall result in the imposition by the commissioner of a twenty-five dollar ($25) penalty against the provider. In addition, interest payable by the provider shall accrue on the unpaid fee at the rate of two percent (2%) a month.

(c) Any money received by the commissioner under subsection (b) shall be forwarded to the treasurer of state. The fund, and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the treasurer of state in the same manner as provided in IC 20-49-3-10 for investment of the common school fund.

(d) All reasonable expenses of collecting and administering the fund shall be paid from the fund.

(e) Money in the fund at the end of the state's fiscal year shall

remain in the fund and shall not revert to the general fund.".

Page 1, line 8, delete "requires each resident to provide an average initial life" and insert "**enters into a continuing care agreement with a resident (as defined in IC 23-2-4-1);**

(3) uses the money described in subdivision (2) to provide services to the resident before the resident may be eligible for Medicaid under IC 12-15; and

(4) meets the requirements of IC 23-2-4.".

Page 1, delete lines 9 through 13.

Page 1, line 16, after "(b)" insert "**(c)**".

Page 1, line 16, reset in roman "As used in this SECTION, "nursing facility" means a health".

Page 1, reset in roman lines 17 through 18.

Page 2, reset in roman line 1.

Page 2, line 2, strike "(c)" and insert "**(d)**".

Page 2, line 7, delete "(d)" and insert "**(e)**".

Page 2, line 19, reset in roman "(f)".

Page 2, line 19, delete "(e)".

Page 2, line 35, delete "." and insert ", **subject to the following conditions:**

(A) A nonprofit organization that is:

(i) exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code; and

(ii) registered under IC 23-2-4 before July 1, 2009;

is not required to meet the definition of continuing care retirement community in subsection (a).

(B) A continuing care retirement community that does not meet the provisions of clause (A)(i) and (A)(ii) must meet the definition set forth in subsection (a).".

Page 3, line 6, reset in roman "(g)".

Page 3, line 6, delete "(f)".

Page 3, line 22, reset in roman "(h)".

Page 3, line 22, delete "(g)".

Page 3, line 27, reset in roman "nursing".

Page 3, line 27, delete "health".

Page 3, line 28, reset in roman "(i)".

Page 3, line 28, delete "(h)".

Page 3, line 39, reset in roman "(j)".

Page 3, line 39, delete "(i)".

Page 4, line 3, reset in roman "(k)".

Page 4, line 3, delete "(j)".

Page 4, line 7, reset in roman "(l)".

Page 4, line 7, delete "(k)".
Page 4, line 16, reset in roman "(m)".
Page 4, line 16, delete "(l)".
Page 4, line 20, reset in roman "(n)".
Page 4, line 20, delete "(m)".
Page 4, line 25, reset in roman "(o)".
Page 4, line 25, delete "(n)".
Page 4, line 25, reset in roman "nursing facility or a".
Page 4, line 28, reset in roman "(p)".
Page 4, line 28, delete "(o)".
Page 4, line 33, reset in roman "(q)".
Page 4, line 33, delete "(p)".
Page 4, line 37, reset in roman "(r)".
Page 4, line 37, delete "(q)".
Page 4, line 40, reset in roman "nursing".
Page 4, line 40, after "nursing" insert "**facility and each**".
Page 5, line 5, reset in roman "(s)".
Page 5, line 5, delete "(r)".
Page 5, line 6, reset in roman "nursing facility and each".
Page 5, line 7, reset in roman "(r)".
Page 5, line 7, delete "(q)".
Page 5, line 7, reset in roman "nursing facility's or".
Page 5, line 10, reset in roman "nursing facility's or".
Page 5, line 11, reset in roman "nursing facility or the".
Page 5, line 13, reset in roman "(t)".
Page 5, line 13, before "An" delete "(s)".
Page 5, line 13, reset in roman "(s)(2)".
Page 5, line 13, delete "(r)(2)".
Page 5, line 16, reset in roman "(u)".
Page 5, line 16, delete "(t)".
Page 5, line 32, reset in roman "(v)".
Page 5, line 32, delete "(u)".
Page 5, after line 32, begin a new paragraph and insert:
"SECTION 6. **An emergency is declared for this act.**".
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 454 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.